PATIENT REGISTRATION

Name_____Preferred/Nickname_____

Gender (must match insurance card)____DOB_____SSN_____Age_____

E-mail_____
This practice may send you an email notification through **Patient Fusion** which is a secure messaging portal regarding your appointment, bill or general health information. By giving us your email address you consent to us contacting you this way.

Address_____Apt_____City_____State_____Zip_____

Patient Race_____Occupation_____

Primary Phone _____

IN CASE OF EMERGENCY
Name_____Relationship_____

Primary Phone_____Secondary Phone_____

BILLING INFORMATION
Primary Insurance Carrier_____

Are you the Subscriber? Yes No

Subscriber Name_____Relationship_____DOB_____

Secondary Insurance Carrier_____

Are you the Subscriber? Yes No

Subscriber Name_____Relationship_____DOB_____

PREFERRED PHARMACY
What pharmacy do you use?_____ZIP Code_____

Whom may we thank for the kind referral?_____Relationship_____

_____ _____
Patient Signature Date

Patient Name:_____**DOB**_____

Do you have a Primary Care Physician? Yes No
If No,would you like us to be your Primary Care Physician? Yes No

SOCIAL HISTORY
Current Smoker? Yes No Former Smoker? Yes No Chewing Tobacco? Yes No
Do you drink Alcohol? Yes No Is it a problem: Yes No
Do you Exercise? Yes No If **Yes** what type?_____How Often?_____

Hobbies_____
Number of Children_____Years of birth_____

SURGICAL HISTORY ☐ NONE
List Surgeries and/or hospitalization you have had with Date.

_____ _____
_____ _____
_____ _____

ONGOING MEDICAL ISSUES ☐ NONE

_____ _____
_____ _____
_____ _____

DO YOU HAVE SEASONAL, ENVIRONMENTAL OR FOOD ALLERGIES? ☐ NONE

_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES ☐ NONE
List any allergies to medication and any type of reaction.

_____ _____
_____ _____
_____ _____

FAMILY AND PERSONAL HISTORY
Specify if you or a blood-relative have or had any of the following

Heart Attack_____ **Diabetes**_____ **High Cholesterol** _____
Heart Disease_____ **High Blood Pressure**_____ **TB**_____
Stroke_____ **Cancer**_____ **Glaucoma**_____

Patient Name_____ **Date of Birth**_____ **Today's date:**_____

Privacy Practices and Health Updates

HIPPA PRIVACY PRACTICES: I have read and understand laminated HIPPA form at front desk **INITIAL**:_____
Permission for us to share healthcare and/or billing information:

Name_____Relationship_____
Circle one or both: Healthcare information Billing information
Name_____Relationship_____
Circle one or both: Healthcare information Billing information

PREVENTIVE CARE year of your latest**:** Physical_____Colonoscopy_____

Latest prostate exam_____ Latest Prostate Blood Test (PSA)_____Latest Testosterone level_____

Date last period_____Age of first period_____Cycles irregular or regular (circle one)

What form of birth control do you use?_____Are you satisfied with it? Yes no (circle one)
Date Bone Density Test_____Date last Mammogram_____Date of your latest pap smear: month___ year____

History abnormal pap or mammogram? Yes no (circle one) if yes, details: _____

IMMUNIZATIONS: Year latest Flu____ Pneumonia____ DTAP (tetanus)____ Hep A/B____ Guardasil___
Shingles_____

Were you born between 1946- 1964? Yes No (circle one) if Quest order HCV Ab reflex to HCV RNA PCR quant

Medication/Vitamin/Supplement Name	Dosage	Strength

SLEEP
Do you ever doze while doing the following: **0**=never **1**=slight chance **2**=moderate chance **3**=high chance
Sitting and reading ___ Watching TV___ Sitting inactive in public place___ Sitting and talking___ Passenger in a car 1hr___In a car stopped for a few minutes___ Lying down to rest in afternoon ___ Sitting quietly after lunch without alcohol ____ **TOTAL SCORE**_____ Have you ever been told that you snore? (circle one) Yes No
Do you have difficulty getting or staying asleep? (circle one) Yes No

CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and any recommended medical or diagnostic procedure after being advised of risks and hazards involved. **It is the patient's responsibility to pay copay or deductible amount at time of visit.** This is information so you may give or withhold your consent to the visit.

This form has been fully explained to me. I have read it or had it read to me and I understand its contents.

_____

Name of PATIENT (Printed) DOB Date

_____

Signature of PATIENT (OTHER LEGALLY RESPONSIBLE PERSON) / relation to patient

DOWNTOWN DOCTOR FINANCIAL POLICY

Thank you for choosing Downtown Doctor for your health care needs. We are committed to providing you with quality care. The purpose of this financial policy is to better inform and advise you of your responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided.

- **INSURANCE** We participate in most insurance plans, including Medicare. We submit claims for your visits to insurance plans with which we are in network. Payment in full is expected at the time of service including co-pays and deductibles. Knowing your insurance costs and coverages is your responsibility.
- **AFTER HOURS' FEE** appt after 5pm, before 8am, on Saturday will be billed to insurance. If insurance puts to patient responsibility you will be responsible $38 for this convenience
- **CANCELLATION/NO CALL NO SHOWS** If you are late or cancel appt less than 48 business hours prior to scheduled appt charge $75 for procedure $120
- **PROOF OF IDENTITY AND INSURANCE.** All patients must provide proof of ID and valid insurance card prior to being seen by Doctor/PA.
- **CLAIMS SUBMISSION** We submit your claim. Your insurance company may need you to supply additional information to them directly. Any claims not covered by your insurance that is put to patient responsibility you are responsible for including after hours' fee
- **CHANGES TO YOUR INFORMATION** Notify us of address, phone or insurance changes prior to next appointment to maximize your benefits
- **NONPAYMENT** After the first statement is sent out and is not paid within 30 days, the second statement will have a late charge fee of $5 added to the balance and if balances more than 90 days it will be sent to collections with an additional 40% added to balance.
- **RETURNED CHECKS** Our office charges $ 38 fee for a returned check
- **BILLING INFORMATION** If you have any questions about your account, please contact our billing company at 512.391.9400. You can pay bills through our portal: **www.PayStatementOnline.com** You can also mail payments to us: 1611 W. 5th Street, Suite 180, Austin, Texas 78703.

I have read and understand the payment policy and agree to abide by its guidelines:

Today's Date_____ Signature_____Date of Birth_____

CONTROLLED SUBSTANCE AGREEMENT

I, (print name)_____ Date of Birth _____ understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following.

- **MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT** If I am currently involved in mental health therapy, or if I enter such therapy per instruction of Doctor/PA, I authorize my mental health practitioner to exchange unrestricted information regarding pain (complete shared medical information in Office Policies and Procedures)
- **USE OF MEDICATION** I will take all medications as prescribed. I will not make any change in dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medication must all be obtained from the same pharmacy each time (exceptions must be approved by Doctor/PA). I will abstain from alcohol use. I will not obtain the controlled substance/s which I receive here from another Doctor/PA
- **DRUG SCREENING** I will participate in drug screening as a part of my treatment plan. I understand that drug screening may be conducted at any of my office visits or I may be called to come in to provide a urine sample. Screening may include urinalysis, blood testing and/or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services. The Downtown Doctor does not discriminate; we drug screen all patients from whom we prescribe chronic narcotics or any controlled substances.
- **ILLEGAL AND NON-PRESCRIBED DRUG USE.** I understand that the use of any controlled medication not prescribed by the practice may result in termination of care. I understand the Downtown Doctor cooperates fully with city, state & federal law enforcement agencies as well as the Texas board of Pharmacy. I understand that the use of any illegal substance, may result in termination of care.
- **LOST OR STOLEN MEDICATIONS** will not be replaced.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL MY QUESTIONS ABOUT THE TERMS OF THE AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THE AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

Signature _____ Today's Date_____